MaineCare Services
An Office of the
Department of Health and Human Services

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Thank you for your interest in becoming a MaineCare provider. This is the MaineCare Provider Enrollment packet you requested.

It includes:

1. An enrollment checklist
2. Instructions for completing the Provider Enrollment Form
3. The Provider Enrollment Form
4. A list of provider type codes
5. The Provider/Supplier Agreement
6. W-9 form with "Paid To" address
7. A note for billing agents
8. Instructions for completing the Billing Agent/Clearinghouse Registration Form
9. The Billing Agent/Clearinghouse Registration Form
10. EMC Rider (Electronic Media Claims)
11. Instructions for completing the Servicing Provider and Locum Tenens Enrollment Form
12. The Servicing Provider and Locum Tenens Enrollment Form
13. Physician sub-specialty codes (Provider 006)
14. A list of servicing provider specialty codes
15. EFT Rider (Authorization agreement for direct deposit for contractors/vendors)
16. DME Storefront Rider
17. Addendum One
18. Rider A (Rate Agreement Rider, when applicable, to certify the seed funding)
19. Supplemental provider form for PHPOT (Prevention, Health Promotion and Optional Treatment Services)
20. Request for MaineCare primary Care Provider Enrollment
21. Behavioral Health Services Rider

Send completed forms and other required information to:

Maine Department of Health and Human Services
Office of MaineCare Services
MaineCare Provider Enrollment Unit
11 State House Station
Augusta, ME 04333-0011

Contact information

Call the MaineCare Provider Enrollment Unit at 1-800-321-5557 option 6 with any questions. You can access provider enrollment forms on the Office of MaineCare Services website www.maine.gov/bms. Click on the "Provider Enrollment" link on the right.

1. Checklist

When filling out forms, please follow the instructions carefully and attach all requested information.

Note: To be enrolled as a MaineCare provider, you must have a current license; not be indebted to the Department or, if indebted, have made arrangements for payment; have had no sanctions imposed; or have had no findings of fraud or abuse as described in Section 1.17 and 1.18 of the MaineCare Benefits Manual.

Check off when completed

☐ Each and every blank is filled; NA is written in those that do not pertain to me

☐ All of the *applicable* requested information listed below is enclosed:

- ☐ Signed provider enrollment form
- ☐ Signed Servicing Provider and Locum Tenens enrollment form
- ☐ All 8 pages of a signed Provider/Supplier Agreement. Make a copy for your records.
- ☐ W-9 form signed with the most recent "Paid To" address
- ☐ Signed DME provider storefront rider
- ☐ Billing agency information/update form
- ☐ Supplemental riders/agreements as applicable, for example:
  1. Prevention, Health Promotion and Optional Treatment Services supplemental agreement
  2. The MaineCare electronic media claims rider
  3. Addendum One for Maine RxPlus; Drugs for the Elderly (DEL) and Medical Eyecare
- ☐ Authorization agreement (EFT Rider) for direct deposit services for contractors or vendors
- ☐ Copy of all license(s) for servicing providers
- ☐ Copy of all license(s) for group/facility/agency/organization
- ☐ Copy of CLIA certificate for lab services
- ☐ Any agency approvals (such as DHHS rate letter, Medicare certifications, State agency letter of approval, public health letter of supervision, HRSA grant approval, etc.)
- ☐ Copy of DEA number for all providers who prescribe medications
- ☐ All documents have required signatures and dates

2. Instructions for Completing the MaineCare Provider Enrollment form

This is not the form to use to enroll new employees or billing agencies/clearinghouses.

- If you are enrolled as a MaineCare provider and you want to enroll one or more new employees as servicing providers, fill out Form 12, *The Servicing Provider/Locum Tenens Form.*
- If you are enrolling as a billing agency/clearinghouse, fill out form 9, *The Billing Agency/Clearinghouse Information Form*.

Use this form if:

- You're a licensed provider who can bill MaineCare directly either through your office or through a billing agency and you want to enroll as a MaineCare provider; or
- You are currently a MaineCare provider and you want to add a new location(s) to your file; or
- You are currently a MaineCare provider and you want to change or update information.

General Instructions

- Don't leave any spaces unfilled unless instructed otherwise. If information is not applicable, write NA on the line or in the box provided. This will ensure that you don't inadvertently miss providing needed information. If the information you submit to MaineCare is not complete or you don't include the signatures and dates, we will return the packet to you and it will delay the enrollment process.
- Attach copies of all pertinent licenses and/or certifications for the enrolling provider(s) as directed in the instructions. These include copies of professional licenses, agency/facility licenses, DHHS rate letter, Medicare certifications, State agency letter of approval, public health letter of supervision for dental hygienists, HRSA grant approval, Rider A, CDS approval, Board Certification, etc., as appropriate.

Instructions for Completing the Provider Enrollment Form Instructions

1. Enrollment type: Must check one box – no need to write NA in other boxes.
   - Individual: check this if you are the only person providing services.
   - Group: check this if you are enrolling as a group of two or more licensed professionals. Each individual in the group must also fill out Form 12, *Servicing Provider/Locum Tenens Form*, because each professional in the group will need his or her own servicing provider number in order to bill MaineCare.
   - Facility/agency/organization: check this if this describes your entity.

Out-of-state: check this if you are an out-of-state provider and don't meet the MaineCare border criteria. (Within 15 miles of the State of Maine border in New Hampshire or within 5 miles of the US

Instructions for Completing the MaineCare Provider Enrollment form

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Use this form if:

- You're a licensed provider who can bill MaineCare directly either through your office or through a billing agency and you want to enroll as a MaineCare provider; or
- You are currently a MaineCare provider and you want to add a new location(s) to your file; or
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General Instructions

- Don't leave any spaces unfilled unless instructed otherwise. If information is not applicable, write NA on the line or in the box provided. This will ensure that you don't inadvertently miss providing needed information. If the information you submit to MaineCare is not complete or you don't include the signatures and dates, we will return the packet to you and it will delay the enrollment process.
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Instructions for Completing the Provider Enrollment Form Instructions

1. Enrollment type: Must check one box – no need to write NA in other boxes.
   - Individual: check this if you are the only person providing services.
   - Group: check this if you are enrolling as a group of two or more licensed professionals. Each individual in the group must also fill out Form 12, *Servicing Provider/Locum Tenens Form*, because each professional in the group will need his or her own servicing provider number in order to bill MaineCare.
   - Facility/agency/organization: check this if this describes your entity.
   - Out-of-state: check this if you are an out-of-state provider and don't meet the MaineCare border criteria. (Within 15 miles of the State of Maine border in New Hampshire or within 5 miles of the US border in Canada.) *If you check this box, MaineCare will cover only emergency services or services that have been authorized.*
2. Application

   Must check one box – no need to write NA in other boxes.
   - For new enrollment: Check this if you have never been a MaineCare provider
   - To change existing information: Current or former MaineCare providers should check this box to change or update information
   - To add additional location: Check if adding new location and fill out section 5 to record new address
3. Name of individual, group or facility
4. Contact

- First and Last Name of the person MaineCare should contact with questions
- Title of contact person: For example, Office Manager, MD, DO, etc
- Telephone and fax: Telephone and fax number for the contact person

5. Physical Address: physical location of provider, business or entity
   - Doing business as: Name of the business
   - Street Address 1: street or road where provider/owner, business or entity is physically located (*may be different from mailing address*)
   - Street Address 2: additional line for address if needed (or write NA)
   - City, state/province/zip code
   - Country
   - Telephone
   - Fax number
   - E-mail address
6. Mailing Address
   - Street Address 1: mailing address of the provider/owner, business or entity
   - Street Address 2: additional line for address if needed (or write NA.)
   - City, state/province/zip code
   - County
7. Pay to address: *This address must match W-9 and must be filled out.* Do not write NA
   - Street address 1: Paid To address of the provider/owner, business or entity that receives the MaineCare payment
   - Street address 2: additional line for address if needed (or write NA)
   - City, state/province/zip code
   - County
8. Type of entity: **Must check one box to indicate the nature of ownership of your practice or business. No need to write NA in other boxes.**
   - Public: a publicly traded organization
   - Private: a privately owned business
   - Charitable: run as a not-for-profit organization such as a 501(c)3
   - Other: any entity, such as *tribal*, that doesn't meet the definitions of public, private or charitable
9. Required identifying information
   - SSN (Social Security Number): required of a provider who enrolls as an individual, or the owner of the group or business. If there is more than one owner, attach a list of the names and social security numbers of any provider owning 5% or more of the business
   - FEIN: Federal Employer Identification Number assigned to the business
   - UPIN: Universal Provider Identification Number assigned by Medicare
   - NPIN: National Provider Identification Number assigned by CMS

- License Number: Write number of the enrolling provider's professional or agency/business license and attach a copy. If unsure, or if enrolling as a group, please refer to *Specialty/Sub-specialty information*, which lists provider documentation requirements, including the need for, and type of, license
- License effective date: Date on which professional or agency/business license became effective *Your provider number will not be effective any sooner than your license effective date*
- License expiration date: Last date on which professional or agency/business license is effective
- CLIA#: Clinical Laboratory Improvement Amendments number required for all laboratory services. **List all CLIA numbers assigned to you** and attach copy of license(s). Duplicate this page of the enrollment form if you need additional space for CLIA numbers.
- DEA #: The provider's Drug Enforcement Agency number required for all prescribers. Attach copy of the DEA document.
- NABP #: The National Association of Boards of Pharmacy number required of all pharmacies. Attach copy.
- Medicare ID #s: There is room to list four numbers. You must list all Medicare ID numbers assigned to you. Duplicate this page of the enrollment form if additional space is needed.
- Current MaineCare ID #: if applicable. If not, write NA.
- Prior MaineCare Provider ID #s: List all prior MaineCare Provider ID numbers assigned to you. Duplicate this page of the enrollment form if you need additional space.

10. Do you plan to provide, or are you currently providing, the following services? **Must be answered by physicians, physician's assistants and nurse practitioners. All others write N/A.**

    PT (Provider Type) 20 (Specialties 006 Physicians, 060 Nurse Practitioners and 108 Physician's Assistants) and PT 26 (Specialties 063 FQHC, 043 RHC) must answer a, b and c.

    Provider Type 26 (subspecialty Family Planning (subspecialty 025)) must answer a and b.

    Check "Yes" if you currently provide or plan to provide preventive services to adults age 21 and over. Complete form 20*, PHPOT Supplemental Provider Agreement Form*. Contact the Provider Relations Unit at 1-800-321-5557 for additional information concerning these services.

    Check "Yes" if you currently provide or plan to provide PHPOT (Prevention, Health Promotion and Optional Treatment) services to children under the age of 21. Complete form 20*, PHPOT Supplemental Provider Agreement Form*. Contact the Provider Relations Unit at 1-800-321-5557 for additional information concerning these services.

    Check "Yes" if you currently provide or are planning to provide MaineCare Managed Care Primary Care Network Services. Only physicians, physician's assistants and nurse practitioners can provide Managed Care Primary Care. Complete a MaineCare managed care rider and the managed care forms. Call 1-866-796-2463 for additional information concerning this program and forms.

11. How will you submit claims? **Check all that apply**

- Web: Check if submitting claims via the Web, when this option is available.
- Electronic batches: Check if submitting claims via electronic batches (i.e., FTP). If you have never billed MaineCare electronically, you must submit the attached form 11, *EMC Rider*. For questions regarding electronic submissions, call (207) 287-4082.
- Paper: Check mailing paper claims
- Billing agency name: Fill this out if a billing agency will be submitting your claims for processing. Make sure your billing agency is registered with the Office of MaineCare Provider Enrollment Unit (Contact at 207-287-4082).
- Telephone number: The telephone number of the billing agency

- Current MaineCare ID of billing agency: The MaineCare ID number assigned to your billing agency by MaineCare
- Begin date: Date on which the billing agency will begin submitting claims for you
- End date: Last date billing agency will be submitting claims for you

12. Ownership Information

    An individual provider is considered the owner. Duplicate this page of the enrollment form as many times as needed to provide information on all who own 5% or more of the business. If this is a non-profit organization/agency, please attach names and addresses of board members.

    - First Name: First name of the owner (if owner is an individual)
    - Last Name: Last name of the owner (if owner is an individual)
    - FEIN: Federal Employer Identification Number assigned to the business entity
    - SSN: Owner's Social Security Number
    - Begin date of ownership: Date on which individual/business entity became the owner
    - End date of ownership: Last date on which individual/business was owner
    - Doing business as: Name of business
    - Mailing address 1 and 2.
    - City, state/province, zip code, country

13. Facility Information

    - Fiscal year end date: Last date of the facility, agency, or organization's fiscal year
    - Accreditation:

      Accredited: Check this box if the facility has received accreditation from an agency approved by CMS (Centers for Medicare and Medicaid Services), such as JCAHO, CARF, COA or CHAP.

      Non-Accredited: Check this box if your facility has not received accreditation.

    - Do you have a distinct part unit? A distinct part unit is a separate psychiatric, rehabilitation, or skilled nursing unit attached to a hospital. The hospital is paid under the prospective payment system (PPS) but the unit is paid on a cost reimbursement or other non-PPS basis. (If yes, complete location specific information for each distinct unit in block 12 and duplicate as needed.)
    - State facility ID #: case mix ID /3 assigned to medical or remedial PNMI or nursing facility
    - Number of licensed beds: Number of licensed beds within the facility, agency, or organization

14. Provider Type: **This is the 2-digit code that identifies your provider category. Refer to document 4: *Provider Type Codes* for information.)**

15. Specialty/subspecialty information

    - Specialty code: 3-digit code that identifies specific services you plan to provide. Duplicate this page if you need additional space for specialty codes. For a list of codes, refer to the document titled: *Specialty/Sub-specialty information*.
    - Subspecialty: 3-digit code that further identifies specific services you will be providing. If unsure a subspecialty is required, please refer to the document titled: *Specialty/Sub-specialty information*. To find your sub-specialty code, first find the specialty under which you practice.
    - Begin date: First date on which the provider can provide services for the subspecialty code indicated. MaineCare policy states that (a) Section 1.03-1 (D): MaineCare enrollment normally will be effective the first day of the month the Provider [Enrollment] Unit receives the complete enrollment package. In no case will the effective enrollment date be earlier than the date of licensure, or the effective date of the service contract agreement, if required by another chapter of this manual; (b) Section 1.03-1 (E): In the

case of retroactive enrollment for Federally Qualified Health Centers (FQHCs), the retroactive FQHC enrollment will be effective on the date of the FQHC's HRSA or CMS grant, not before. In the case of retroactive enrollment for rural health clinics (RHC), retroactive enrollment will be effective on the date of the Medicare approval.

- End date (if applicable): Last date on which provider can perform services for the subspecialty indicated

16. Legal Information: **Please read carefully and answer yes or no for each question.**

    If you answer "yes" to any of these questions, please attach explanation. The individual answering the legal questions must sign and date the enrollment form.

Provider/Supplier Agreement: Make a copy of this for your files

This agreement must be read and signed by the owner if this enrollment is for an individual. If this enrollment is for a group or entity, a person with authority, e.g., the CEO, CFO, partner or superintendent, must sign. Make a copy of the document for your files and return all pages to MaineCare.

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3. Provider Enrollment Form

Do not use this form to enroll a Servicing Provider, Locum Tenens or Billing Agency. See instructions.

1. **Enrollment type:** If not sure, refer to document titled *Specialty/Sub-specialty information*.
   ☐Individual ☐Group ☐Facility/Agency/Organization ☐Out-of-state
2. **Application:** ☐For new enrollment ☐To change existing information ☐To add additional location
3. **Name of individual, group or facility:** _____
4. **Contact**
   First Name: _____ Last Name:
   Title of contact person: _____ Telephone: _____Fax:
5. **Physical address:**
   Doing business as: _____
   Street Address 1: _____
   Street Address 2: _____
   City: _____State/Province: _____Zip code: _____ County:
   Telephone: _____Fax: _____E-mail:
6. **Mailing address (if different from physical address):**
   Street Address 1: _____
   Street Address 2: _____
   City: _____State/Province: _____Zip code: _____County:
7. **Pay-to address (Must match W-9):**
   Street Address 1: _____
   Street Address 2: _____
   City: _____State/Province: _____Zip code: _____County:
8. **Type of entity:** ☐ Public ☐private ☐charitable ☐other (explain below)

Provider Enrollment Form, page 2

9. Required identifying information:

SSN: _____FEIN: _____UPIN: _____NPIN:

License # _____ License Effective Date: _____ License Expiration Date:

CLIA #: 1._____2. _____ 3.

DEA#: _____NABP# (Pharmacy Only): _____

Medicare ID #s: a. _____ b. _____ c. _____d.

Current MaineCare ID #: _____ Prior MaineCare ID #s: a. _____ b.

MaineCare ID #s, continued: _____

10. Do you plan to provide, or are you currently providing the following services (certain providers only-see instructions):

Prevention services for adults (age 21 and over): ☐ Yes ☐ No ☐ NA

Prevention, Health Promotion, and Optional Treatment Services for members under 21 (formerly EPSDT) ☐ Yes ☐No ☐ NA

MaineCare managed care primary care provider services: ☐ Yes ☐ No ☐ NA

11. How will you submit claims: (check all that apply)

☐ Web ☐ Electronic batches ☐ Paper

☐ Billing agency (If the billing agency is not enrolled in MaineCare, the agency must complete the Billing Agency Enrollment form.)

Billing agency name: _____

Telephone number: _____Current MaineCare ID:

Begin date: _____ End date: _____

12. Ownership information: If non-profit, please attach names and addresses of board members

First Name: _____ Last name:

FEIN: _____Begin Date of Ownership: _____End Date of Ownership:

Doing business as: _____

Mailing address 1: _____

Mailing address 2: _____

City: _____State/Province: _____Zip code: _____ County:

13. Facility information

Fiscal year end date: _____ Accreditation: ☐ Accredited ☐Non-Accredited

Do you have a distinct part unit: ☐ Yes ☐ No

State facility ID #:_____ Number of licensed beds: _____

Provider Enrollment Form. Page 3

14. Provider type: _____

15. Specialty/subspecialty information:

	Code	Begin date	End date		Code	Begin date	End date
Specialty 1	_____	_____	_____	Specialty 2	_____	_____	_____
subspecialty 1	_____	_____	_____	subspecialty 1	_____	_____	_____
subspecialty 2	_____	_____	_____	subspecialty 2	_____	_____	_____
subspecialty 3	_____	_____	_____	subspecialty 3	_____	_____	_____

16. Legal Information

If you answer "yes" to any of these questions, please attach explanation on separate piece of paper.

Have any owners or employees ever had an Assessment taken against you? .....Yes ☐... No ☐

Have any owners or employees ever had an Administrative Sanction taken against you? .....Yes ☐... No ☐

Have any owners or employees ever had a Suspension of Payment taken against you? .....Yes ☐... No ☐

Have any owners or employees ever had a Restitution Order taken against you? .....Yes ☐... No ☐

Have any owners or employees ever had a Program Exclusion taken against you? .....Yes ☐... No ☐

Have any owners or employees ever had a Program Debarment taken against you?.....Yes ☐... No ☐

Have any owners or employees ever had a Pending Criminal Judgment taken against you? .....Yes ☐... No ☐

Have any owners or employees ever had a Pending Civil Judgment taken against you?.....Yes ☐... No ☐

Have any owners or employees ever had a Judgment Pending Under False Claims Act taken against you? .....Yes ☐... No ☐

Have any owners or employees ever had a Criminal Fine taken against you?.....Yes ☐... No ☐

Have any owners or employees ever had a Civil Monetary Penalty taken against you?.....Yes ☐... No ☐

Have any owners or employees ever been convicted of any health related crimes? .....Yes ☐... No ☐

Have any owners or employees ever been convicted of a crime involving the abuse of a child or an elderly adult? .....Yes ☐... No ☐

Do any owners or employees have ownership interest in any entity that provides services to a MaineCare provider/supplier? .....Yes ☐... No ☐

I certify that the information contained herein is true, correct, and complete. If I become aware that any information in this form is not true, correct or complete, I agree to notify the MaineCare Provider Enrollment Unit of this fact immediately.

I authorize the MaineCare Provider Enrollment Unit to verify the information contained herein. I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.

_____

Signature Date

4. Provider Type Codes

Provider Type	Description
10	Behavioral Health Services
11	Chiropractic Services
12	Dental Services
15	Eye & Vision Services
18	Pharmacy/DME & Supplies
20	Physicians/Assistants/Nurses
21	Podiatry
22	Rehabilitative & Restorative Services
23	Speech, Language & Hearing Services
24	State Psych Hospital
25	Private Psych Hospital
26	Ambulatory Health Care Facility
28	Hospitals
29	Laboratory Services
31	Nursing & Custodial Care/Boarding Homes
34	Transportation/Ambulances
37	Home Care Services
42	BDS-MR Bureau
45	Non-Medicaid Vendor
49	Indian Health Services
50	Waiver Services
55	Educational Related Services
56	Medical Imaging

5. Provider/Supplier Agreement

MAINECARE/MEDICAID PROVIDER AGREEMENT

This is a Provider Agreement for participation in the MaineCare/Medicaid program. This Agreement is made by and between the State of Maine Department of Health and Human Services ("Department"), 11 State House Station, Augusta, ME 04333-0011, and

Date: / /

Legal Name of Applicant or Provider (hereinafter jointly referred to as "Provider")		Business Name (if different than legal name)
Business Telephone Number		
Taxpayer Identification Number	National Provider Identifier(s)	MaineCare Provider Number(s), if applicable
Business Address (number, street) City State		Nine-digit ZIP code
Mailing Address (number, street, P.O. BOX number) City State		Nine-digit ZIP code
Pay-to-Address (number, street, P.O. BOX number) City State		Nine-digit ZIP code
Physical Location of Additional Sites Associated with this Agreement		

The Provider agrees to comply with all of the following terms and conditions:

A. GENERAL REQUIREMENTS

1. Conditions of Participation. As a condition of participation or continued participation as a provider in MaineCare, the Provider agrees to comply with the provisions of the Federal and State laws and regulations related to Medicaid, the provisions of the MaineCare Benefits Manual ("MBM"), 10-144 C.M.R. Ch. 101, the terms and conditions of the Provider Enrollment Packet, including all attachments, completed by the Provider, which is incorporated herein by reference, and the terms and conditions of this Provider Agreement ("Agreement").

2. Changes in Federal or State Laws or Regulations.

a) Any change in Federal or State law or regulation that conflicts with or modifies any term of this Agreement will automatically become a part of this Agreement on the date such a change in statute or regulation becomes effective.

b) If the Provider objects to the application of the change in Federal or State law or regulation, it must notify the Department within thirty (30) calendar days of the effective date of the change that it will terminate the Agreement as set forth in Chapter I of the MBM. Failure to so notify the Department will be deemed acceptance of the change in law or regulation as part of this Agreement.

3. Independent Capacity. The parties agree that in the performance of this Agreement, the Provider, including any officers, directors, agents and employees of the Provider, shall act in an independent capacity and not as officers, agents or employees of the State. The Provider further understands and agrees that it is an independent contractor for whom no Federal or State Income Tax will be deducted by the Department, and for whom no retirement benefits, survivor benefit insurance, life insurance, vacation and sick leave, and similar benefits available to State employees will accrue.

4. Subletting, Assignment or Transfer.

a) The Provider shall not subcontract, transfer, assign, or otherwise convey this Agreement or any portion thereof, or any of its rights, title, interest, including the Department billing number issued to the Provider, or obligations under the Agreement, without written request to and prior written consent from the Department. The Provider shall not reassign its MaineCare claims in a manner prohibited by 42 C. F. R. § 447.10.

b) No subcontracts, assignments or transfers shall in any case release the Provider of its legal obligations or other liability under this Agreement, unless otherwise provided by law.

c) Any subcontracts approved by the Department will bind the subcontractor to compliance with applicable Federal and State laws and regulations.

d) The Department, in its sole discretion, will determine whether a change of name, location or ownership may be recognized by the Department by amendment to this Agreement or whether this change will require a new Agreement to be executed.

5. Certification.

a) The Provider certifies that no individual practitioners, owners, directors, officers or employees of the Provider or any other organization on whose behalf the Provider is signing this Agreement, or any contractor retained by the Provider or any of the aforementioned persons, is currently subject to sanction under Medicare or MaineCare or debarred, suspended or excluded under any other

Federal agency or program, or is otherwise prohibited from providing services to Medicare or MaineCare members ("Members").

b) The Provider further certifies that at the time that this Agreement is executed neither it nor any of its employees, group members or agents has engaged in any activities prohibited by 42 U.S.C. § 1320a-7b or has been the subject of a criminal conviction or disciplinary action that would disqualify it, its employees, group members or agents from providing services to Members.

c) The Provider agrees that, should it become aware of information of exclusions, convictions, disciplinary actions or other conduct as described in A. 5. a) and b) above, it will notify the Department of such information within the time prescribed in Chapter I of the MBM.

d) The Provider understands that engaging in activity prohibited by 42 U.S.C. § 1320a-7b may result in sanctions or termination of this Agreement, in accordance with applicable Federal and State laws and regulations.

6. Licensing, Certification and Professional Standards.

a) The Provider will adhere on a continuing basis to all applicable Federal and State laws and regulations related to licensing, accreditation, certification and registration and to adhere to other professional standards governing medical care and services, as well as policies and procedures set forth in the MBM, as these may be amended from time to time.

b) Possession of a valid license, accreditation, certification or registration, where required by statute or regulation, in good standing throughout the duration of the Agreement, is a condition precedent to the Provider's participation in MaineCare. Failure to obtain and maintain such license, accreditation, certification or registration as required shall constitute grounds for the Department to terminate, or refuse to extend or renew this Agreement.

7. Prohibition of Rebate, Refund or Discount (Kickbacks).

a) The Provider will not offer, give, furnish, or deliver any rebate, refund, commission, preference, patronage dividend, discount or any other gratuitous consideration in connection with the rendering of services to a Member.

b) The Provider will not solicit, request, accept or receive any rebate, refund, commission, preference, patronage, dividend, discount or any other gratuitous consideration in connection with the rendering of services to any Member or take any other action or receive any other benefit prohibited by 42 U.S.C. § 1320a-7b or the MBM.

c) The Provider will not make any referrals prohibited by 42 U.S.C. § 1395nn *et. seq.* or 22 M.R.S. §2081 *et seq.*

8. Lobbying.

a) No Federal or State appropriated funds shall be expended by the Provider in violation of Federal or State law for influencing or attempting to influence, as prohibited by Federal or State law, an officer or employee of any Federal or State agency, a member of Congress or State Legislature, or an officer or employee of Congress or State Legislature in connection with any of the following covered actions: the awarding of any agreement; the making of any grant; the entering into any cooperative agreement; or the extension, continuation, renewal, amendment or modification of any agreement, grant or cooperative agreement. By signing this Agreement, the Provider declares that it has not engaged in such lobbying activities prohibited by 31 U.S.C. § 1352.

b) If any other funds have been or will be paid to any person in connection with any of the covered actions specified in Section A. 8. of this Agreement, the Provider must complete and submit a "Disclosure of Lobbying Activities" form available at: http://www.whitehouse.gov/omb/grants/#forms.

9. Deficit Reduction/False Claims Act. The Provider will comply with Section 6032 of the Deficit Reduction Act of 2005, codified at 42 U.S.C. § 1396a (a) (68), and the requirements of the False Claims Act 31 U.S.C. § 3729 *et seq*. Providers subject to this provision are responsible for developing written policies, handbooks and education as required by Chapter I, Appendix 3, of the MBM for all employees that include detailed information about the False Claims Act and any other provisions required by 31U.S.C. § 3729 *et seq.* or 42 U.S.C. § 1396a (a) (68).

10. State Employees not to Benefit/Conflict of Interest. The Provider shall assure that no individual employed by the State, at the time this Agreement is executed or any time thereafter, shall be admitted to any share or part of this Agreement or to any benefit that might arise from the Agreement, directly or indirectly, due to his or her employment by or financial interest in the Provider or any affiliate of the Provider, as prohibited by 5 M.R.S. § 18 or 17 M.R.S. § 3104.

11. Information Provided to the Department.

a) The Provider will supply the Department with complete and accurate information in the Provider Enrollment Packet, including any attachments, and throughout the term of this Agreement, when and in the manner required by the MBM, including but not limited to, information regarding ownership and control, required by 42 C.F.R. Part 455, Subpart B, and licensure.

b) The Provider agrees that failure to provide complete and accurate information required by this Agreement, the MBM and other applicable Federal and State laws and regulations may result in the imposition of the sanctions set out in Federal and State laws and regulations, including but not limited to, termination of this Agreement and recoupment or offset of reimbursement. Intentional falsification or concealment of a material fact may also result in referral of the Provider for prosecution under Federal and State laws.

12. Notices and Information to Provider. The Department will send notices and information to the Provider using the contact information on file with the Provider Enrollment Unit, when and in the manner required by the MBM. It is the Provider's responsibility to keep its contact information up-to-date.

B. SERVICES TO MEMBERS

1. Services to Members/Eligibility.

a) The Provider will provide services, supplies, or equipment to only those individuals whom the Department has declared eligible for MaineCare services ("Members"), in accordance with provisions contained in this Agreement, in the MBM, in Title XIX and XXI of the Social Security Act, and in all other applicable Federal and State laws and regulations.

b) In the event of Department error in determination of Member eligibility, and if such error is not based on incorrect information obtained from or through the Provider, the Department will reimburse the Provider, but to no greater extent than reimbursement for eligible Members under this Agreement.

2. Refusal of Services. The Provider may refuse to render services to a Member only in accordance with the MBM and this Agreement.

3. Choice of Provider. The Provider will assure that the Member is receiving services under this Agreement by the provider of his or her choice, and that referrals to other providers of service will not interfere with a Member's freedom of choice in seeking medical care from any institution, agency, pharmacy or person who is qualified to perform a required service. If a Member is under 18 years of age or mentally incapable of choice of provider, the Provider will assure that the Member's legally authorized representative makes such choices for the Member, unless the Member is authorized to make this choice under Federal or State law.

4. Nondiscrimination in Member Services. The Provider agrees that in its performance of this Agreement it will not discriminate in any way against any Member, or in its hiring and employment practices, because of race, color, sex, sexual orientation, religious creed, ancestry, national origin, age, or physical or mental handicap or disability, or any other factor as specified in the Maine Human Rights Act, 5 M.R.S. § 4551 *et seq*., the Federal Civil Rights Act, 42 U.S.C. § 1981 *et seq*., The Americans With Disabilities Act of 1990, 42 U.S.C. § 1201, or the Federal Rehabilitation Act, 29 U.S.C. § 504 *et seq*. The Provider will comply with 5 M.R.S. § 784(2) and any and all appropriate Federal and State laws and regulations regarding such discrimination.

5. Behavioral Health Services. Independent Practitioners providing Behavioral Health Services pursuant to MBM, Section 65, must comply with the following requirements:

a) If the Independent Practitioner is using a crisis provider for after-hours coverage, the Independent Practitioner is required to have in place an explicit written agreement for after-hours coverage with the local crisis provider.

b) The Independent Practitioner will discuss sharing information with other providers of care with the Member in order to assure continuity of care, and the Independent Practitioner will obtain authorization from the Member as necessary.

c) The Independent Practitioner will participate in treatment planning with other providers as requested.

C. RECORD AND DOCUMENTATION REQUIREMENTS

1. Records and Documentation.

a) The Provider will maintain in a systematic and orderly manner, medical and financial records that are necessary to document fully the extent, nature and cost of the services provided to Members receiving assistance under this Agreement, as required by the MBM and applicable professional standards. The records must be maintained in the form, if any, required by the Department.

b) The Provider will maintain all records necessary to verify compliance with Federal or State laws and regulations regarding licensing, accreditation, certification and registration.

2. Confidentiality of Records. The use or disclosure by the Provider of any information concerning Members for any purposes not directly connected with the administration of the MaineCare program and the administration of the Department's or the Provider's responsibilities with respect to services provided under this Agreement is prohibited. The use and disclosure of protected health information is also governed by other applicable Federal and State laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), so long as these other laws and regulations are not inconsistent with laws and regulations related to the Medicaid/MaineCare program.

3. Retention of Records.

a) The Provider will retain all medical, financial, administrative and other records and documents required by the MBM relating to the Member's medical history, care received and verification of services and products furnished, for at least five (5) years from the date of service.

b) If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the 5-year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular 5-year period, whichever is later. If an audit or review of records is initiated within the required retention period, the records must be retained until the audit or review is completed and a settlement, if necessary, has been made. Any retention of records beyond the period required by Section C. 3. a) of this Agreement will be determined by each Provider based on regulation or the usual and customary practice in the specialty or profession, or other laws and regulations.

c) The Provider acknowledges that failure to maintain all required documentation may result in sanctions set out in the MBM, including the disallowance and recovery by the Department of any amounts paid to the Provider for which the required documentation is not maintained and provided to the Department upon request.

4. Utilization Review/Quality Assurance. The Department may conduct periodic utilization review of services provided under this Agreement. All records, including minutes of Utilization Review/Quality Assurance by the Provider, shall be made available to representatives from the Department. The purpose of such review is to assure the appropriateness, the quality and the timeliness of services delivered. Findings of such reviews will be shared with the Provider and appropriate recommendations and plans for Department action will be discussed with the appropriate administrative and professional staff of the facility or Provider.

5. Access.

a) At all reasonable times during the prescribed retention period, persons duly authorized by the Department or the Federal government, whether employees or under contract, shall have the right to full access to inspect, review, or audit all medical, quality assurance documents, financial, administrative records, and other documents and reports required to be kept under Federal and State laws and regulations by Provider or its sub-contractors, including the records of non-members who reside in facilities that receive MaineCare funds. Those duly authorized also shall have the right to obtain copies of such records at no expense to the Federal or State government.

b) The Provider and its sub-contractors shall give the Department complete and private access to the Provider's staff and to any resident or Member for the purpose of reviewing the Provider's compliance with this Agreement, the MBM and other applicable Federal and State laws and regulations, including laws or regulations related to licensing and certification.

D. PROVIDER REIMBURSEMENT

1. Reimbursement. The Department will reimburse the Provider for MaineCare services provided to Members in accordance with the provisions of the MBM. Reimbursement is contingent on the Provider's, its agents' and employees' compliance with applicable Federal and State Medicaid laws and regulations, the MBM, and the terms and conditions of this Agreement, including but not limited to, the following requirements:

a) Provider Agreement. The Provider must have in effect a written Provider Agreement with the Department that has been properly executed and is in effect.

b) Prior Authorization. If the Provider fails to seek and receive prior authorization for services, as required by the MBM, it will not receive reimbursement for those services.

c) Payor of Last Resort. Subject to the third party liability provisions included in Chapter I of the MBM, reimbursement is contingent upon the Provider billing to the Department only as the payor of last resort. The Providers must take all necessary and reasonable measures within the Provider's ability to identify, locate and bill any and all third-party payors, including Medicare, prior to billing MaineCare pursuant to this Agreement.

d) Payment Only for Medically Necessary Services Rendered. The Provider shall be reimbursed by the Department only for medically necessary care and services actually provided to, or in the case of certain facilities, reserved for an eligible Member under the provisions of this Agreement or the MBM.

e) Billing Procedures. The Provider must submit bills in accordance with methods and procedures contained in the MBM and billing instructions issued by the Department. The Provider is expressly responsible for understanding and applying applicable regulations and requirements for proper billing. The Provider is also responsible for requesting instruction or training, available from the Department, if uncertain as to the application of these regulations and procedures.

2. Additional Remuneration Prohibited. The Provider shall consider the Department's reimbursement as payment in full and shall not charge or accept additional remuneration from any Member, relative, friend, payee, guardian/conservator, attorney of the Member, or any other person, or other State agency, for reimbursed services provided under this Agreement. This section does not prevent the Provider from receiving compensation for non-covered services from the Member, relative, friend, payee, guardian/conservator, attorney of the Member, or from any other person, or other State agency, provided required notice is given in accordance with the MBM.

3. Liability of Provider for Debts Owed to the Department.

a) The Provider will report any moneys received in error or in excess of the amount to which the Provider is entitled from the MaineCare program and refund promptly such moneys to the Department, in accordance with the requirements of the MBM.

b) The Department may collect any debts, including overpayments, through offset or recoupment against amounts owed by the Department to the Provider, or any other method of collecting debts, consistent with relevant statutory and regulatory provisions, including 22 M.R.S.A. § 1714-A. In addition, the Department may utilize any other available method, allowed by law, for the collection of debt. The Department's decision to exercise or not to exercise one method of recovery shall not preclude it from pursuing other methods allowed by law.

c) The liability for debts owed to the Department by the Provider is enforceable against the Provider, including any person who has an ownership or control interest in the Provider, and against any officer, director or member of the Provider who, in that capacity, is responsible for any control or any management of the funds or finances of the Provider.

d) The Provider agrees that if it is a provider group, the group and each member of the group, is jointly and severally liable for any breach of this Agreement, and that action by the Department against any of the group members may result in action against all of the members of the provider group.

e) This Agreement may be terminated solely on the basis of the Provider's unpaid fines, debts, including overpayments and penalty assessments, to Federal, State or local government health care programs.

f) If a Provider is liable for or has outstanding debts due to the Department and such Provider undertakes to sell or transfer the Provider's operations or business or a substantial portion of the assets of the Provider's operations or business, the Provider must notify the purchaser(s), successor(s), transferee(s) or assignee(s), of such debt or liability; and if such debt or liability is not paid by the Provider prior to the sale or transfer, the purchaser(s), successor(s), transferee(s) or assignee(s) shall withhold a sufficient amount of the purchase money to cover the amount of the liability. A purchaser, successor, transferee or assignee who fails to withhold a sufficient amount of the purchase price may be jointly and severally liable for the payment of the liability or debt due to the Department.

E. MISCELLANEOUS PROVISIONS

1. Amendments. The terms and conditions of this Agreement may be amended only in writing. Amendments must be signed by an authorized representative of the Provider and the Department before they become effective.

2. Choice of Law and Forum. This Agreement is governed in all respects by the laws and regulations of the United States of America and the laws of the State of Maine. This provision shall not be construed as waiving any immunity to suit or liability, including without limitation sovereign immunity in Federal or State court, which may be available to the Department or the State of Maine. Any legal proceeding against the State regarding this Agreement must be brought in the State of Maine administrative or judicial forums. The Provider consents to personal jurisdiction in the State of Maine.

3. Indemnification. The Provider agrees to indemnify, defend and hold harmless the Department, its officers, agents, and employees from and against any and all claims, suits, judgments, liabilities, damages and costs, including reasonable attorney's fees, arising from the intentional conduct, negligent acts or omissions of the Provider, its employees, agents, officers, members or subcontractors in the course of providing services to a Member, or to a person believed to be a Member, pursuant to this Agreement.

4. Notices.

a) The Provider shall give the Department immediate notice in writing of any claim, legal action or suit filed by or against the Provider that is related in any way to the Agreement or which may affect the performance of duties under the Agreement, including but not limited to, notice of a bankruptcy action, loss of or change in incorporation or licensure status.

b) Any other notices required by this Agreement and the MBM shall be provided in accordance with the requirements of the MBM.

5. Waiver. The failure of the Department to insist, in any one or more instances, upon the performance of the Provider of any of the terms, covenants or conditions of this Agreement or to exercise any of the Department's rights pursuant to this Agreement, or under Federal or State laws and regulations, shall not be construed as a waiver of future performance by the Provider or waiver of the right of the Department to seek sanctions against the Provider for future breaches of the Provider's obligations under the Agreement, or to otherwise enforce the Agreement under a remedy allowed by law. The obligation of the Provider with respect to such future performance shall continue.

6. Severability. Any provision of this Agreement that is contrary to applicable Federal or State laws or regulations is void and unenforceable. The Agreement will be interpreted as if the void provision is omitted. The omission of any provision found to be void will not affect the ability of the parties to enforce the remaining provisions of this Agreement.

7. Entire Agreement. This Agreement, as amended in accordance with E.1), and attachments, if any, contains the entire Agreement of the parties and neither party shall be bound by any statement or representation not contained therein.

8. Survives Termination. The Provider's obligations under paragraphs C.1) through C.3), C. 5), D. 3), and E.2) through E.4) survive the termination of this Agreement.

9. Termination, Suspension and Non-Renewal. Chapter I of the MBM governs the notices and other procedures related to emergency termination, voluntary termination by either party, termination by the Department for cause, or suspension and non-renewal.

10. Effective Date and Duration. The effective date of this Agreement is that date when both the Provider and the Department have executed the Agreement. On its effective date, this Agreement supersedes and replaces any existing contracts or agreements between the parties related to the provision of goods or services to Members pursuant to this Agreement. This Agreement shall remain in full force until it is terminated in accordance with the MBM or as otherwise required by Federal or State laws or regulations.

IN WITNESS WHEREOF, and in consideration of the mutual covenants set forth above and other valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties execute this Agreement, and by their signatures found below, agree to be bound by its terms and conditions.

By: _____ _____
Provider Signature Date

_____
Provider Name (printed)

_____
Title

By: _____ _____
Provider Signature Date

_____
Provider Name (printed)

_____
Title

By: __Department of Health and Human Services _____
Date

_____
Director or Designee

January 13, 2009

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ____
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

Or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here — Signature of U.S. person ▶ — Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

7. A Note for Billing Agents

Note to providers:
This is for electronic claim submission only. **If you are submitting paper claims, there is no need to fill out this form.**
If you indicated in question 9 of the provider enrollment form that you will be submitting claims electronically via a Billing Agency/Clearinghouse, make sure the Billing Agency/Clearinghouse is enrolled to submit claims to MaineCare.

If the Billing Agency/Clearinghouse is not enrolled, they must complete and return this form. If your Billing Agency/Clearinghouse is not willing to enroll, your claims cannot be processed electronically in the new claims system.

If the Billing Agency/Clearinghouse is enrolled to submit claims to MaineCare electronically, you and the Billing Agency/Clearinghouse must complete form 11*, EMC Rider* and include it with your enrollment.

8. Instructions for completing the Billing Agency/Clearinghouse enrollment form – for electronic claims only

If you plan to bill ONLY paper claims, do not complete this form. This is for electronic claims only.

For questions regarding electronic submissions, call the Electronic Data Unit at (207) 287-4082.

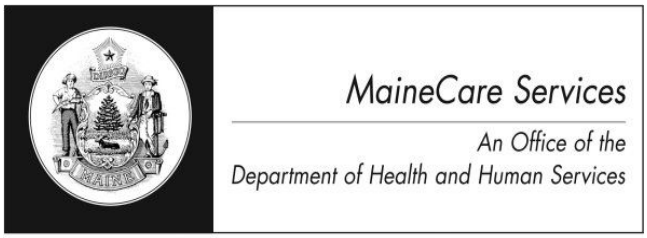
Billing Agency/Clearinghouse information/update form – Don't leave any blank spaces

If you have questions about how to complete this form, please contact the Provider Enrollment Unit at 1-800-321-5557, Option 6.

Please provide all requested information. Do not leave any spaces blank. If information is not applicable, write NA. If the information you submit to MaineCare is not complete or signatures and dates not included, we will return the packet to you and it will delay the enrollment process.

1. **Application to:** Must check one box.
   - Register: check this box if you are enrolling for the first time.
   - Update information: check this box if you are already enrolled but your information has changed.
2. **Billing Agency/Clearinghouse name:** Name of individual or business
3. **Doing business as:** Name of business
4. **Street address 1:** Mailing address where owner or business is located
5. **Street address 2:** Additional line for address if needed (or write NA)
6. **City, state/province/zip code, country**
7. **Telephone and fax**
8. **Current MaineCare ID#**
9. **Prior MaineCare ID#s:** Write number is you have provided MaineCare services in the past or write N/A.
10. **FEIN: Federal Employer Identification Number,** if one is assigned to the Billing Agency/Clearinghouse

    SSN: Social Security Number assigned to the individual owning the Billing Agency/Clearinghouse, if applicable
11. **Contact Person First and Last Name**
12. **How Will You Be Submitting Claims:** Check all that apply.



9. **Billing Agency Clearinghouse Registration Form**

Application to: ☐Register ☐To change existing information

Name of Billing Agency/Clearinghouse: _____

Doing Business As: _____

Street Address 1: _____

Street Address 2: _____

City: _____State/Province: _____Zip code: _____Country: _____

Telephone: _____Fax: _____

Current MaineCare ID: _____

Prior MaineCare IDs: a. _____ b. _____ c. _____

SSN: _____FEIN: _____

Contact Person First name:_____ Last name:_____

How will you submit claims: (check all that apply)

☐ Web ☐ Electronic Batches ☐ Paper

I certify that the information contained herein is true, correct, and complete. If I become aware that any information in this form is not true, correct or complete, I agree to notify the MaineCare Provider Enrollment Unit of this fact immediately.
I authorize the MaineCare Provider Enrollment Unit to verify the information contained herein.
I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.

_____

Signature Date

10. MaineCare Electronic Media Claims Rider

This Rider permits the electronic generation of claims that will be acceptable to the Department in lieu of written claims. This Rider sets forth requirements under which the Provider and the Department will operate:

Section A: Responsibilities of the Provider
Section B: Responsibilities of the Department
Section C: Ratification

Section A

Provider's Responsibilities

1. The Provider agrees to submit claims to the Department only in the format specified by the Department.
2. The Provider agrees that the Department, Secretary of Health and Human Services or designees have the right to audit and confirm information submitted by the Provider and shall have access to all original source documents, including medical and financial records.
3. The Provider agrees to research and correct any and all discrepant claims submitted to the Department.
4. The Provider agrees to assume the responsibility to prepare or submit claims and to be solely responsible for errors, omissions and liabilities, regardless of whether claims are submitted by the Provider or by a billing agent.
5. The Provider agrees to assume all costs of hardware and software needed to facilitate the submission of electronic media claims (EMC).
6. The Provider will furnish to the Department the name of the billing agent, the telephone number, and a contact person in the event a billing agent is used for the submission of EMC.
7. The Provider acknowledges that the Provider or the Department may terminate this Rider with a 30-day written notice to the other party.

Section B

Department's Responsibilities

The Department agrees to furnish the Provider with the specifications for submission of electronic media claims.

The Department agrees to maintain a phone line to send and receive data and a separate phone line which the Provider may use to address any issues or problems related to claims submission, claims processing and/or remittance information.

The Department agrees to produce data on paid/denied claims. Processed claims will be listed on each remittance statement and sent directly to the Provider for purposes of comparison and verification.

The Department acknowledges that the Department or the Provider may terminate this Rider with a 30-day written notice to the other party.

Section C

Ratification

In witness whereof, and as consent to this Rider, the parties herein have executed this Rider and ratified it by their signatures found below:

By: _____ _____

Provider's Signature | Date

_____ _____

Provider's Name (printed) | Title

_____ _____

Facility Name | Provider number

_____ _____

E-Mail Address | Phone Number

If using a billing service, please provide the following: (please do not list your software vendor)

_____ _____

Name of billing service | Phone number

_____ _____

Contact person | User ID

By: Department of Health and Human Services _____

Date

_____ _____

Department Signature | Title

Please give us information about your software

Hyperterminal _____

PROCOMMPlus4.8 _____

Other: _____

Confirmation information: *If you are billing directly to the stat*e, you must choose one of these options.

Phone number of computer to receive call: _____

Email address of person to receive report: _____

Fax number: _____

11. Instructions for Completing the Servicing Providers and Locum Tenens Form

Each agency or group practice must complete one form for each servicing provider for whose services they bill. Make as many copies as you need. Each employee must be licensed.

Application to: Must check one box. If terminating provider, write date of termination.

1. Enrolling as: **Must check one box:**

- Servicing providers are employed by an agency or group practice. The agency or group practice bills MaineCare for services provided by the servicing provider.
- Locum Tenens are licensed physicians who fill in for MaineCare servicing providers in an agency or group practice.

2. **Servicing/Locum Tenens Provider Information: Must complete all fields**

- First Name
- Last Name
- SSN
- DEA# include copy (If not applicable, write NA)
- License Number and copy of license
- License Effective Date
- License Expiration Date
- Hire and End Dates: First and last date on which the servicing Provider/Locum Tenens can perform services. In no case will the effective enrollment date be earlier than the date of licensure, or the effective date of the service contract agreement, if required by another chapter of this manual; (b) Section 1.03-1 (E).

3. **Specialty/Subspecialty:** 3-digit code that identifies specific services to be provided by the servicing Provider/Locum Tenens (see attached list for codes). Only physicians (Specialty 006) can list sub-specialties as a servicing provider.

For a list of physician sub-specialties, see *Specialty/Sub-specialty information*.

For all other servicing provider types, see 13. Servicing Provider Specialty Codes. Those providers listed in italics can only be servicing providers.

4. **MaineCare Billing Provider Information**

- Billing Provider name
- MaineCare Billing Provider ID (if more space is needed, make as many copies of the form as you need).

5. Do you plan to provide, or are you currently providing the following services? Must be answered by physicians, physician's assistants and nurse practitioners. All others write N/A.

PT (Provider Type) 20 (Specialties 006 Physicians, 060 Nurse Practitioners and 108 Physician's Assistants) and PT 26 (Specialties 063 FQHC, 043 RHC) must answer a, b and c.

Provider Type 26 (subspecialty 025 Family Planning) must answer a and b.

a) Check "Yes" if you currently provide or plan to provide preventive services to adults age 21 and over. Complete form 19 *PHPOT Supplemental Provider Agreement Form*. Contact the Provider Relations Unit at 1-800-321-5557 for additional information concerning these services.

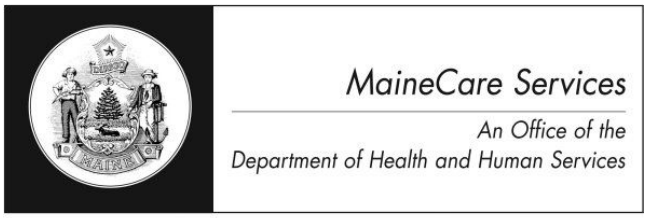
b) Check "Yes" if you currently provide or plan to provide PHPOT (Prevention, Health Promotion and Optional Treatment) services to children under the age of 21. Complete form 19 *PHPOT Supplemental Provider Agreement Form*. Contact the Provider Relations Unit at 1-800-321-5557 for additional information concerning these services.

c) Check "Yes" if you currently provide or are planning to provide MaineCare managed care primary care services. Complete the *MaineCare Managed Care Rider* and the managed care forms. Call 1-866-796-2463 for additional information concerning this program and forms. Only physicians, physician's assistants and nurse practitioners can provide managed care primary care.

6. Legal information

Please read carefully and answer yes or no for each question. If you answer "yes" to any of these questions for any of the servicing providers, please attach an explanation.

The individual answering the legal questions must sign and date the form.



12. Servicing Provider or Locum Tenens Form

Each agency or group practice must complete one form for each servicing provider for whose services they bill. Make as many copies as you need. Each employee must be licensed.

Application to: ☐ Add provider ☐ Terminate provider ☐ Update information

If terminating provider, date of termination: _____

Enrolling as: ☐ Servicing provider ☐ Locum Tenens

Servicing provider/locum tenens information:

First Name: _____ Last Name:

SSN: _____ DEA #: _____License Number:

License Effective Date: _____ Expiration Date:

Hire Date: _____ End date:

Specialty/subspecialty information. Only Provider Type 006 can list a sub-specialty.

	Code	Begin date	End date		Code	Begin date	End date
Specialty 1	_____	_____	_____	Specialty 2	_____	_____	_____
Subspecialty 1	_____	_____	_____	subspecialty 1	_____	_____	_____
subspecialty 2	_____	_____	_____	subspecialty 2	_____	_____	_____
subspecialty 3	_____	_____	_____	subspecialty 3	_____	_____	_____

MaineCare Billing Provider information:

Billing Provider name: _____ Phone:

Billing Provider ID #: _____ Billing Provider ID #:

Billing Provider ID #: _____ Billing Provider ID #

Does the servicing provider/locum tenens plan to provide, or is he or she currently providing, the following services (certain providers only-see instructions):

a. Prevention services for Adults (age 21 and over) Yes ☐ No ☐ NA ☐

b. Prevention, Health Promotion, and Optional Treatment Services for members under 21 (formerly EPSDT) Yes ☐ No ☐ NA ☐

c. MaineCare managed care primary care provider services Yes ☐ No ☐ NA ☐

Legal Information

If you answer "yes" to any of these questions, please attach explanation on separate piece of paper.

Have any owners or employees ever had an Assessment taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had an Administrative Sanction taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had a Suspension of Payment taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had a Restitution order taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had a Program Exclusion taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had a Program Debarment taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had a Pending Criminal Judgment taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had a Pending Civil Judgment taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had a Judgment Pending Under False Claims Act taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had a Criminal Fine taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever had a Civil Monetary Penalty taken against you? ..... Yes ☐ No ☐

Have any owners or employees ever been convicted of any health related crimes? ..... Yes ☐ No ☐

Have any owners or employees ever been convicted of a crime involving the abuse of a child or an elderly adult? ..... Yes ☐ No ☐

Do any owners or employees have ownership interest in any entity that provides services to a MaineCare provider/supplier? ..... Yes ☐ No ☐

I certify that the information contained herein is true, correct, and complete. If I become aware that any information in this form is not true, correct or complete, I agree to notify the MaineCare Provider Enrollment Unit of this fact immediately.

I authorize the MaineCare Provider Enrollment Unit to verify the information contained herein. I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.

Signature Date

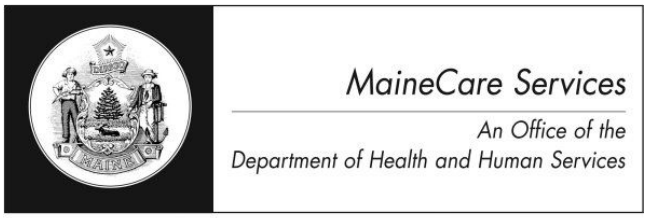
13. Sub-Specialty Codes for Servicing Provider 006 Physician

09 General Practice
110 Family Practice
111 Anesthesiology
112 OB/GYN
113 Psychiatry
114 Preventive Medicine
115 Pediatric Medicine
116 Nuclear Medicine
117 Geriatric Medicine
118 Infectious Disease
119 Addiction Medicine
120 Cardiology
121 Cardiac Surgery
122 Critical Care (Intensivists)
123 Neurology
124 Neurosurgery
125 Allergy/Immunology
126 Dermatology
127 Emergency Medicine
128 Endocrinology
129 Pathology
130 Gastroenterology
131 Hematology
132 Internal Medicine
133 Nephrology
134 Hematology/Oncology
135 Medical Oncology
136 Surgical Oncology
137 Radiation Oncology
138 Ophthalmology
139 Orthopedic Surgery
140 Osteopathic Manipulative Therapy
141 Otolaryngology
142 Physical Medicine & Rehabilitation
143 Pulmonary Disease
144 Diagnostic Radiology
145 Interventional Radiology
146 Rheumatology
147 General Surgery
148 Plastic & Reconstructive Surgery
149 Colorectal Surgery
150 Thoracic Surgery
151 Vascular Surgery
152 Peripheral Vascular Surgery
153 Neuropsychiatry
154 Maxillofacial Surgery
155 Hand Surgery
156 Urology
320 Asthma
326 Diabetes

14. Servicing Provider Specialty Codes

Specialty Code	Specialty Description	
046	Audiologist	
197	Certified Clinical Nurse Specialist (CCNS)	
196	Certified Nurse Anesthetist	
167	*Certified Rehab Counselor*	*Servicing Only*
032	Chiropractor	
104	*Dental Hygienist*	*Servicing Only*
009	Dentist	
105	Denturist	
200	*Family Planning Nurse*	*Servicing Only*
173	*Family Planning Specialist*	*Servicing Only*
168	Independent Behavioral Specialist I	
315	Independent Behavioral Specialist II	
162	*LADC-Licensed Alcohol & Drug Counselor*	*Servicing Only*
013	LCPC-Licensed Clinical Professional Counselor	
160	LCSW-Licensed Clinical Social Worker	
172	*Licensed Dietician*	*Servicing Only*
163	*LMSW-Licensed Master Social Worker*	*Servicing Only*
101	Locum Tenens	
164	*LPC-Licensed Professional Counselor*	*Servicing Only*
199	*LPN-Licensed Practical Nurse*	*Servicing Only*
165	*LSW-Licensed Social Worker*	*Servicing Only*
203	*Master RN*	*Servicing Only*
166	*MSW-Master Social Worker*	*Servicing Only*
053	Nurse Midwife	
060	Nurse Practitioner	
033	Occupational Therapist	
170	*Occupational Therapist Assistant*	*Servicing Only*
042	Optician	
037	Optometrist	
031	Physical Therapist	
171	*Physical Therapist Assistant*	*Servicing Only*
108	*Physician's Assistant*	*Servicing Only*

Specialty Code	Specialty Description	
007	Podiatrist	
161	Psych Examiner	
202	*Psych Nurse*	*Servicing Only*
038	Psychologist	
198	*Registered Nurse*	*Servicing Only*
201	*Registered Nurse Certified (RNC)*	*Servicing Only*
217	*Registered Nurse First Assistant-(RNFA)*	*Servicing Only*
047	Speech Language Pathologist	
159	*Speech Language Pathologist-Assistant*	*Servicing Only*
700	*CADC*	*Servicing Only*



15. EFT Rider for Direct Deposit Services

STATE OF MAINE
AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT SERVICES

Return to:
Office Of The State Controller
Attn: Laurie Andre
14 State House Station
Augusta Me 04333-0014
Phone # 207-626-8445 Fax # 207-626-8447

Please provide all requested information and submit a voided check or deposit slip from your account for verification. We will not process an incomplete form.

Print in ink or type all requested information and notify us **in writing** if and when changes to the information you provide below changes.

You are hereby authorized to electronically transfer payments to the following:

Name of Financial Institution	Account Number
Type of Account: ☐ Checking ☐ Savings	
Name on Account	Transit/ABA Number

Address of Financial Institution	City	State	Zip

for deposit to my/our account and I/we authorize the Agency to initiate credit entries and debit entries (to make corrections) to my/our account at the above named financial institution. Each deposit so made (after any necessary corrections) will be full payment of the amount then due and payable to me/us. I/we agree to notify the Agency's offices immediately upon discovery of any errors resulting from transactions under this authorization and to notify the Agency's offices of any changes that may affect these instructions or the Agency's ability to rely upon them. This authorization may be canceled by me/us at any time by so notifying the Agency in writing. In authorizing the above services to be provided to me/us, I/we agree to hold the Agency and the

State of Maine harmless from any and all loss, cost, damage or expenses I/we may suffer as the result of errors in deposits, credit entries or debit entries caused by persons who are not employees of the Agency or the State of Maine.

Signature of Payee (Benefit Recipient)	Date

SS # of Payee or Authorized Agent Identification Number or Firm's Tax Number

Mailing Address	City	State	Zip

Contact Person	Title of Authorized Agent	Telephone

17. **DME Storefront Rider**

To enroll as a MaineCare provider of medical supplies and DME, you must:

- Have a store with a commercial address from which you sell, rent, or otherwise provide supplies and equipment to MaineCare members
- Not be the sole sales representative for a manufacturer
- Service the supplies and equipment
- Have regular operating hours that you post in a visible location for the general public.

The storefront must be located in Maine or, in New Hampshire within 15 miles of the Maine border; or in Canada within 5 miles of the Maine border.

Complete the Following:

Do you have a storefront within the area defined above? ..... Yes ☐….No ☐

Name of the Storefront: _____

Street Address of the Storefront: _____

Mailing Address: _____

Signature_____ Date: _____

If you answered "No", please read the following:
MaineCare **may** make an exemption to the requirement of a storefront in the following cases:

1. To provide durable medical equipment and supplies to meet a member's emergency medical need when that member resides out of state. MaineCare prior authorization is required and the decision is made at the discretion of the department, which takes into account cost effectiveness and medical necessity; and determines the item cannot be supplied by a MaineCare provider.
2. A provider is a sole provider of a type of cost effective medically necessary DME. This provider may be enrolled only for the purpose of providing that item with prior authorization. The provider my warranty this item.
3. The Department reserves the right to issue a request for proposals or provision of any supply or piece of equipment. The resulting contract may be awarded to an out-of-state provider.

For more information, see MaineCare Benefits Manual, Sec. 60, Medical Supplies and DME at http://www.maine.gov/sos/cec/rules/10/ch101.htm

18. Addendum One

ADDENDUM ONE

This Addendum One shall attach to and regulate Provider/Suppliers providing services under the following programs: Maine Rx Plus, Drugs for the Elderly Benefit (DEL) and the Medical Eye Care Benefits.

In consideration for becoming a Department Provider/Supplier for these benefits, applicant hereby agrees to the following terms and conditions:

The Provider/Supplier shall provide services, supplies, or equipment to only those Members whom the Department has declared eligible for these benefits administered by the Office of MaineCare Services or its successor (hereinafter "Members") in accordance with provisions contained herein, and in all other applicable laws, rules and regulations of the Department, State of Maine, or of the U.S. Department of Health and Human Services.

Provider/Suppliers under the Maine Rx Plus Benefit and Maine Drugs for the Elderly Benefit, shall conform to:10-144, Department of Health and Human Services, Chapter 104 of the Maine State Services Manual and the following sections:

A. Section 1: Administrative Policies and Procedures

B. Section 2: Maine Drugs for the Elderly Benefit (DEL)

C. Section 3: Maine Rx Plus Benefit

Provider/Suppliers under the Medical Eye Care Benefit shall conform to: 10-144, Department of Health and Human Services, Chapter 107, or its successor.

The Provider/Supplier is expressly responsible for understanding and applying the applicable rules, regulations and requirements for proper billing. The Provider/Supplier is also responsible for requesting instruction or training, available from the Department, if uncertain as to the application of these rules and regulations. Billing and payment questions should be directed to the Provider Relations Unit.

RATIFICATION

In witness whereof, and as consent to the entire Agreement, the Provider/Supplier herein has executed this Addendum and ratified it by signature found below: Provider/Suppliers acknowledge they have received a copy of the above described rules.

By:_____ **Date:** _____

Provider/Supplier Signature

STATE OF MAINE
DEPARTMENT OF ADMINISTRATIVE &
FINANCIAL SERVICES
HEALTH & HUMAN SERVICES SERVICE CENTER
11 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0011

JODY L. BRETON, CGFM
DIRECTOR

7.1.1.1

CERTIFIED PUBLIC EXPENDITURES AGREEMENT

7.1.1.2 for Targeted Case Management, Day Treatment, Ambulatory Care Clinic, and School Based Rehabilitative Service Providers

I certify that _____
Name of Agency

has Public

funds in the amount of $_____ to provide services to MaineCare eligible clients for the period July 1, 2009 through June 30, 2010. These public funds will be used solely to provide services under *(select one)*

- ☐ Section 13 of the MaineCare Benefits Manual - Targeted Case Management Services
- ☐ Section 41 of the MaineCare Benefits Manual - Day Treatment Services
- ☐ Section 104 of the MaineCare Benefits Manual - School Based Rehabilitative Services
- ☐ Section 3 of the MaineCare Benefits Manual – Ambulatory Care Clinics
- ☐ Other_____

and are not used as matching public funds to receive federal financial participation in any other Service area.

Public Funds Provided by:

_____

Print Name & Title
of Individual Signing Below:
_____

Signature: _____ Date:

_____

I certify that when

Name of Agency

_____ has

billed MaineCare in the amount of $_____, (amount entered on this line is equal to the amount entered above divided by .2521) further MaineCare billing from this provider shall cease until such time that additional public funds are available and certified.

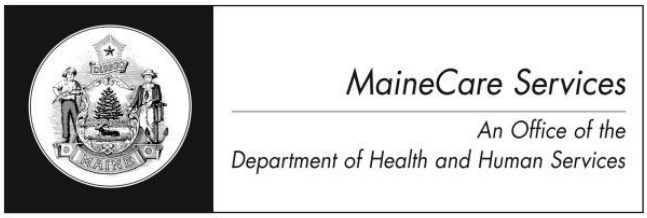
Print Name & Title
of Individual Signing Below:
_____

Signature:_____ Date:

_____

Mail Form to Attention: Debbie Weston

Provider ID:	



20. Supplemental provider form for PHPOT

MaineCare Adult Prevention Benefits

This is to certify that _____, _____
(Provider's Name & Title, PRINTED) (City, State, Zip Code)
agrees to participate in MaineCare Prevention Benefits, providing comprehensive, periodic, and preventive health care services to all MaineCare members **over the age of 20**. Covered screening benefits include but are not limited to those recommended by the United States Preventive Service Task Force.

I. The Department of Health and Human Services shall reimburse screening examiners for preventive examinations and the administration of preventive immunizations.

II. The provider agrees to keep such records as are necessary to disclose fully the extent of the preventive benefits provided. The provider will furnish the Department with such information regarding any payments claimed for providing benefits as the Department may request.

III. This Prevention Benefits Supplemental Agreement may be terminated on thirty (30) days written notice by either party.

*THIS AGREEMENT IS IN ADDITION TO THE PROVIDER AGREEMENT AND INCLUDES ALL CONDITIONS OF THAT AGREEMENT.

MaineCare Prevention, Health Promotion, and Optional Treatment Services

This is to certify that _____ , _____
(Provider's Name & Title, PRINTED)
City, State, Zip Code)
agrees to participate in MaineCare Childrens' Prevention Benefits, providing comprehensive, periodic, and preventive health care services to MaineCare members under the age of twenty-one.

CONDITIONS/ RESPONSIBILITIES:

I. The Department of Health and Human Services shall reimburse screening examiners (providers) for examinations and the administration of immunizations. A higher reimbursement is limited to providers who have agreed to, and in practice comply with, all provisions of the Supplemental Agreement set forth below and the rules in the MaineCare Benefits Manual, Chapter II, Section 90 and Chapter II, Section 94.

Reimbursement shall be made for one screening examination for each age shown on the established periodic schedule. Reimbursement for screening examinations includes payment in full for the screening examination, documentation, and submission of required reports.

II. Screening examiner (provider) agrees to the following:

A. To screen each MaineCare eligible child according to the Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents;

B. To screen each MaineCare eligible child according to the Department's established periodic schedule;

C. To assess the immunization status of individual children and to immunize them at the time of screening when appropriate for age and health history;

D. To refer all children for diagnosis and treatment when problems are suspected or detected by screening; and,

E. To complete and submit the age appropriate Child/Adolescent Health Assessment Report (Bright Futures 19) when requesting reimbursement for Prevention examinations.

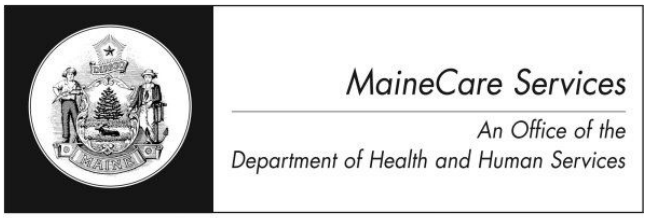
F. The provider will work with local MaineCare Prevention Agencies to ensure that all children screened are provided with referral, diagnosis, treatment, immunizations and follow-up if the screening indicates such.

G. The provider agrees to keep such records as are necessary to disclose fully the extent of benefits provided. The provider will furnish the Department with such information regarding any payments claimed for providing services as the Department may request.

III. This Supplemental Agreement may be terminated on thirty (30) days written notice by either party.
*THIS AGREEMENT IS IN ADDITION TO THE PROVIDER AGREEMENT AND INCLUDES ALL CONDITIONS OF THAT AGREEMENT.
Please check to indicate participation: ☐ **Adults** ☐ **Children** ☐ **Both**

(Signature of Provider or Authorized Agent)	(Date)	(Provider's Social Security Number)

(Name of Practice)	(Practice Site Billing Number)



21. Request for MaineCare Primary Care Provider Enrollment

Primary Care Case Management Primary Care Provider (PCP)

You/your site must be one of the following:

- Family and general practitioners (MD/DO),
- Internist,
- Pediatricians,
- Obstetricians/Gynecologists,
- Physician extenders (Physician Assistant: PA**,** Nurse Practitioners: NP, FNP, CFNP, CPNP)
- Ambulatory Care Centers,
- Federally Qualified Health Centers (FQHC)
- Rural Health Centers (RHC)
- Some outpatient clinics; and
- Other physician specialties as approved by the Department

PCP Network Services will contact the credentialing contact listed below via phone, e-mail or fax in order to enroll the new PCP site and/or PCP.

Are you / your site interested in enrolling into Primary Care Case Management as a Primary Care Provider?
YES_____ NO_____

Please fill out the information below for PCP Network Services enrollment documentation. (Some information may not apply)

Billing Provider Name:_____Billing Provider ID:_____

Credentialing Contact Name:_____Phone:_____

Fax:_____Email:_____

PCP Name:_____Servicing Provider ID:_____
Approval is given in accordance with the MaineCare Benefits Manual, Chapter VI, Section 1, Primary Care Case Management. It is available on the web at
http://www.maine.gov/sos/cec/rules/10/144/ch101/c6s001.doc

22. BEHAVIORAL HEALTH SERVICES RIDER

Independent Practitioners providing Behavioral Health Services pursuant to MaineCare Benefits Manual, Section 65, must comply with the following additional requirements:

1. If the Independent Practitioner is using a crisis provider for after-hours coverage, the Independent Practitioner is required to have in place an explicit written agreement for after-hours coverage with the local crisis provider.
2. The Independent Practitioner will discuss sharing information with other providers of care with the member in order to assure continuity of care and the Independent Practitioner will obtain authorization from the member as necessary.
3. The Independent Practitioner will participate in treatment planning with other providers as requested.

Ratification

In witness whereof, and as consent to this Rider, the parties herein have executed this Rider and ratified it by their signatures found below:

By: _____ _____
Provider's Signature Date

_____ _____
Provider's Name (printed) Title

_____ _____
E-Mail Address Telephone Number

_____
Provider Number